Beginning Billing Workshop Nursing Facility

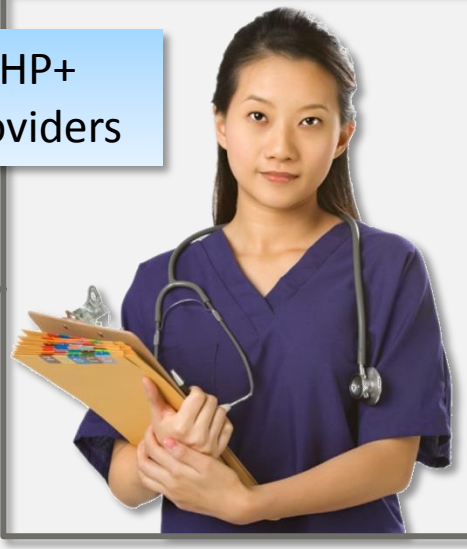
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are timely
  - When to use the CO 1500 paper claim form
  - How to bill when other payers are involved

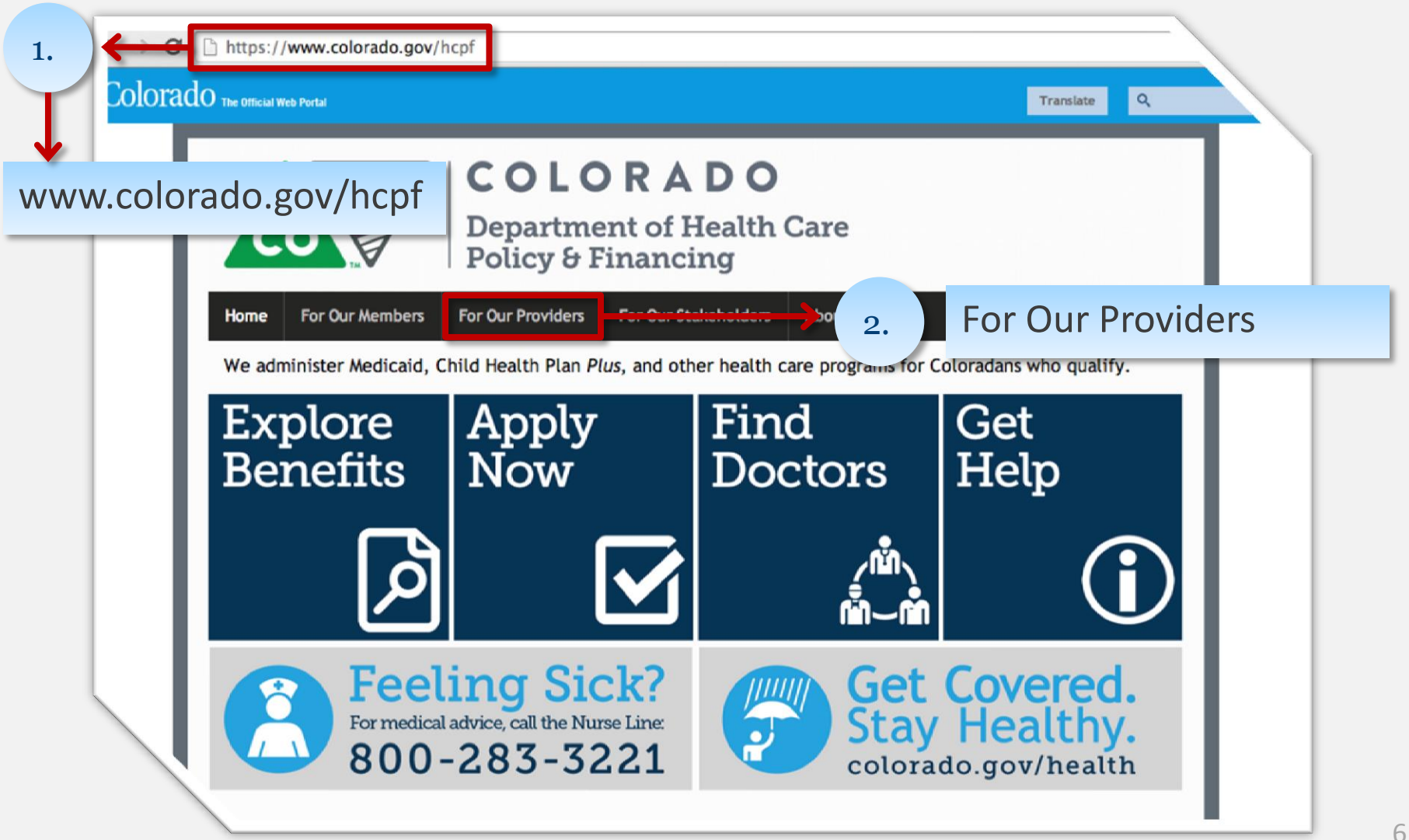
What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

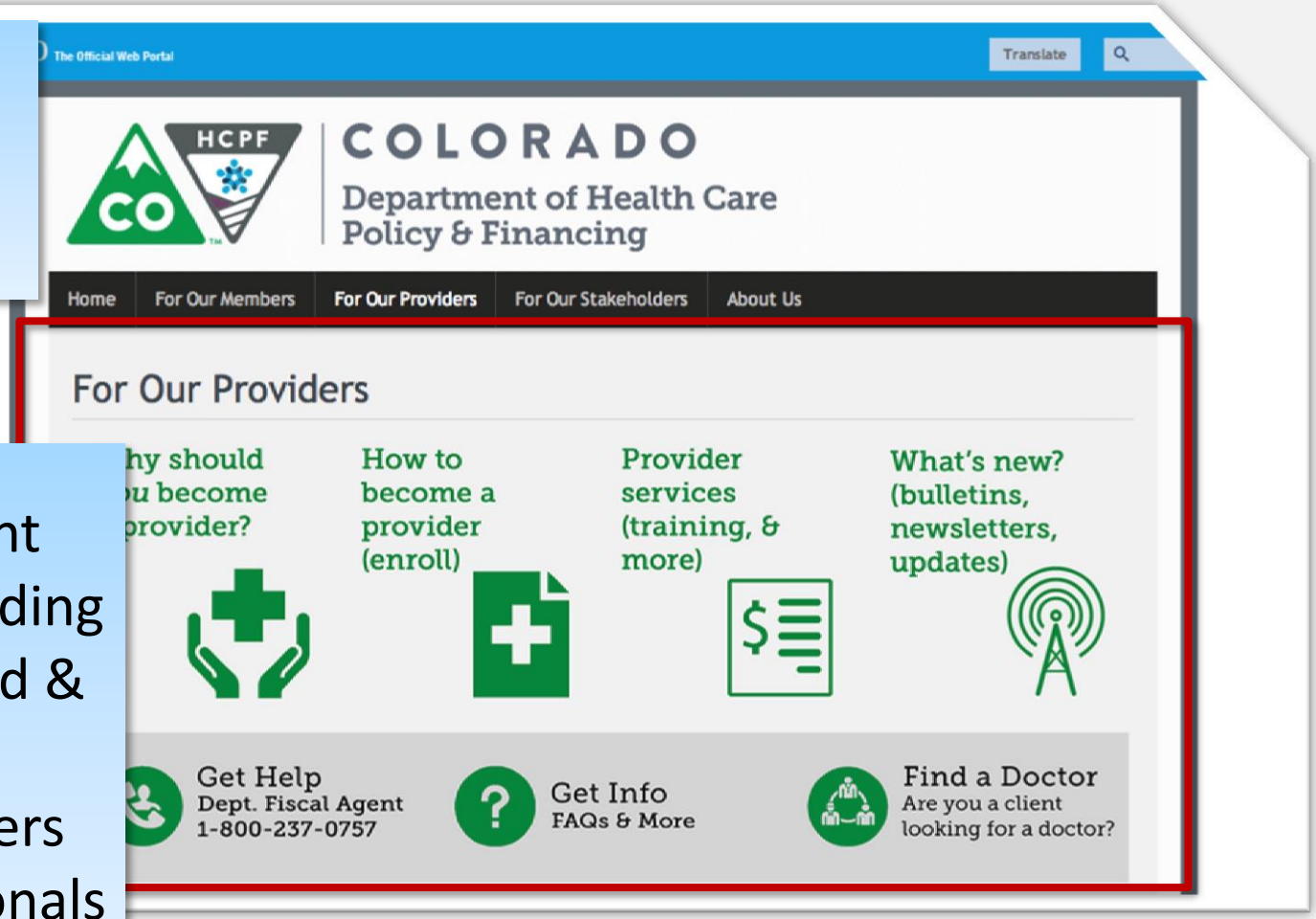
NEW! Department Website



NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals



Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls providers into the Colorado Medical Assistance Program, *not* members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Attending Versus Billing

Attending Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service

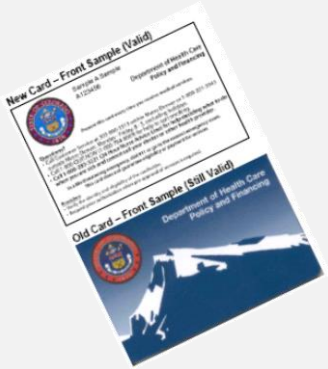
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Web Portal

Fax Back
1-800-493-0920

CMERS/AVRS
1-800-237-0757

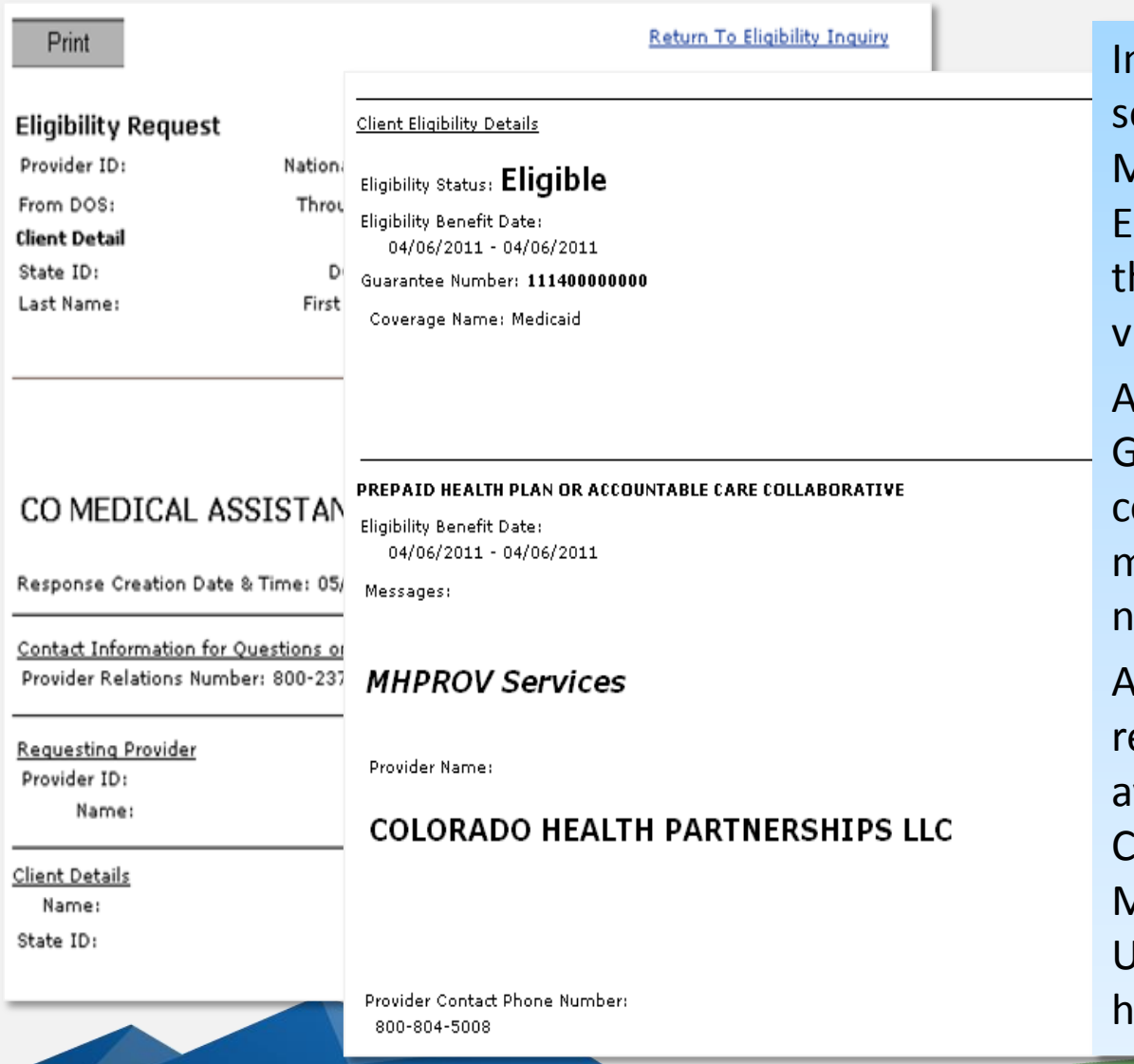


Medicaid ID Card with Switch Vendor

Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

Eligibility Request Response (271)



Information appears in sections (Requesting Provider, Member Details, Member Eligibility Details, etc.). Use the scroll bar to the right to view more details.

A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

As a reminder, information received is based on what is available through the Colorado Benefits Management System (CBMS). Updates may take up to 72 hours.

Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility


Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Managed Care Options

- Types of Managed Care options:
  - Managed Care Organizations (MCOs)
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)

Managed Care Options

Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out

Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

Managed Care Options

Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
- Helps coordinate Member care
  - Helps with care transitions

Medicare

Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always **payer of last resort**
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - **Submission to Medicare prior to** Colorado Medical Assistance Program
  - Medicare denials(s) for **six years**

Third Party Liability

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)
  - Example:
    - Charge = $500
    - Program allowable = $400
    - TPL payment = $300
    - Program allowable – TPL payment = LOP

	$400.00
-	$300.00
=	$100.00

Commercial Insurance

Commercial Insurance

- Colorado Medicaid always payor of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing

Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

Submitting Claims

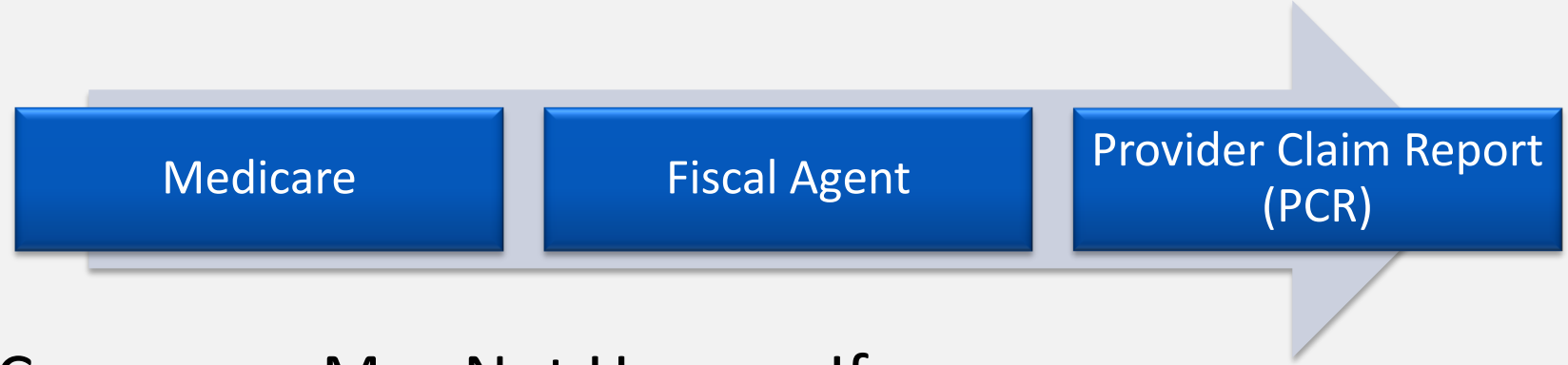
- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor**, **Clearinghouse**, or **Billing Agent**
  - **Paper** only when
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

ICD-10 Implementation Delay

- ICD-10 Implementation delayed until 10/1/2015
  - ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  - ICD-10 codes: Claims with DOS 10/1/2015 or after
  - Claims submitted with both ICD-9 and ICD-10 codes will be rejected

Crossover Claims

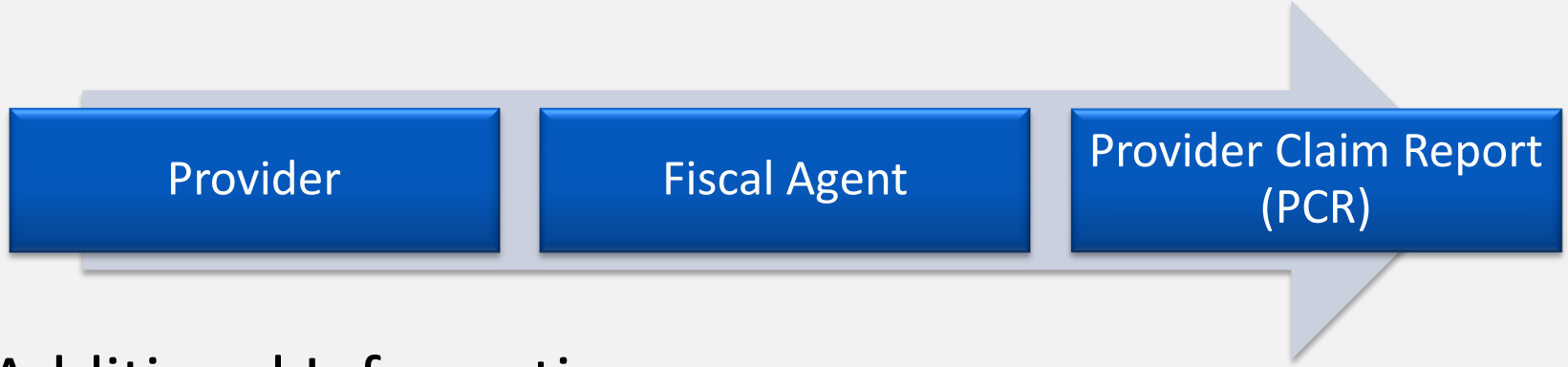
- Automatic Medicare Crossover Process:



- Crossovers May Not Happen If:
  - NPI not linked
  - Member is a retired railroad employee
  - Member has incorrect Medicare number on file

Crossover Claims

- Provider Submitted Crossover Process:



- Additional Information:
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Providers must submit copy of SPR with paper claims
  - Provider must retain SPR for audit purposes

Payment Processing Schedule

Mon.

Payment information is transmitted to the State's financial system

Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

Tue.

Wed.

EFT payments deposited to provider accounts

Paper remittance statements & checks dropped in outgoing mail

Thur.

Fri.

Weekly claim submission cutoff

Sat.

Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Friday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website

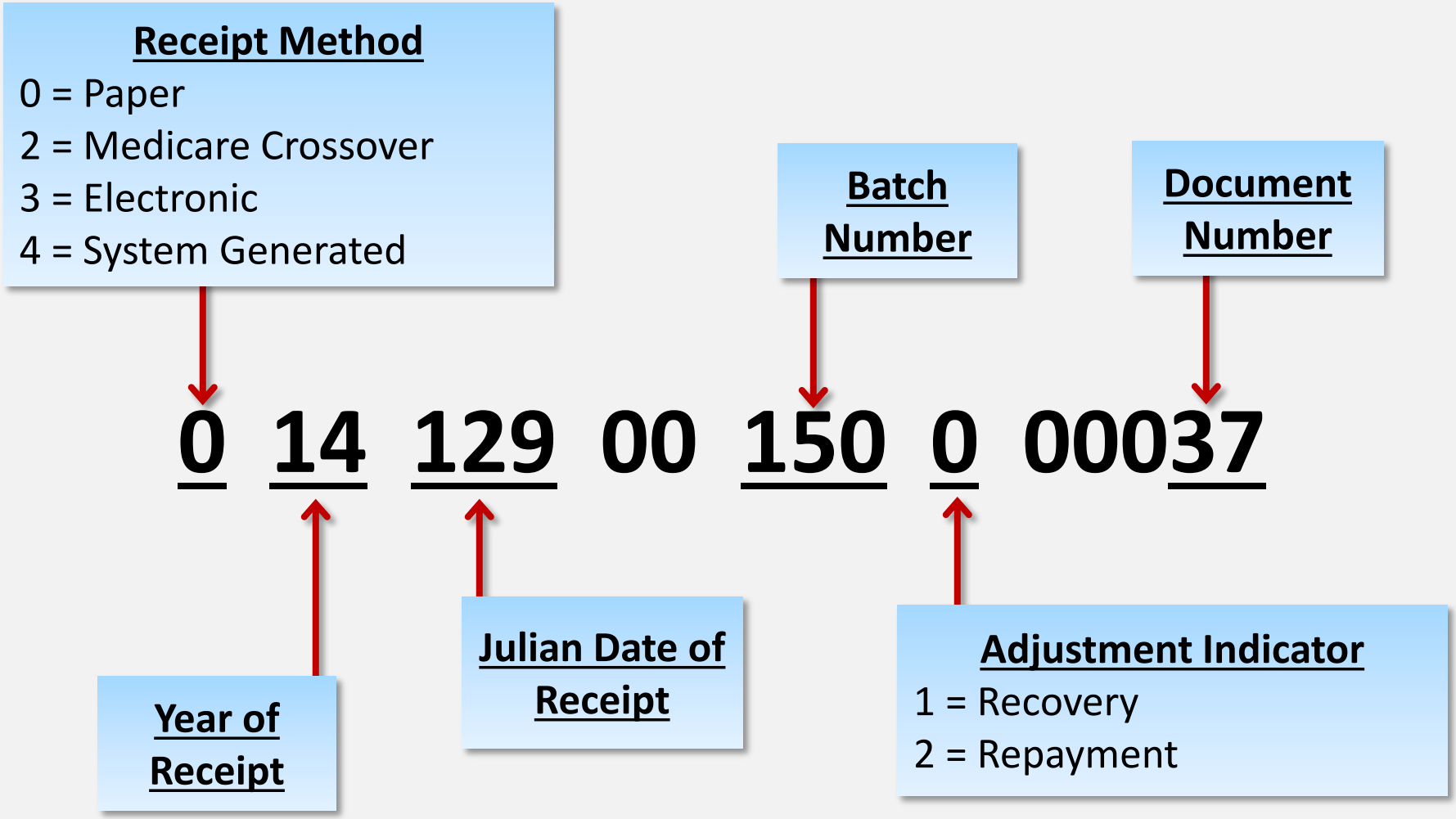
PARs Reviewed by Masspro

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- Long Term Care Nursing Facility PARs only

Mail:
Masspro
CO Long Term Care Manager
245 Winter Street
Waltham, MA, 02451

Phone:
1.855.222.5250
Fax:
1.855.222.5257
Email:
coltc@masspro.org

Transaction Control Number



Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

Timely Filing

From "through" DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS

- FQHC Separately Billed and additional Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837I transaction
  - Keep supporting documentation
- Paper Claims
  - UB-04- Enter Occurrence Code 53 and the date of the last adverse action

Timely Filing – Medicare/Medicaid Enrollees

Medicare **pays** claim

- **120 days from Medicare payment date**

Medicare **denies** claim

- **60 days from Medicare denial date**

Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

Extensions – **Commercial Insurance**

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

Extensions – **Delayed Notification**

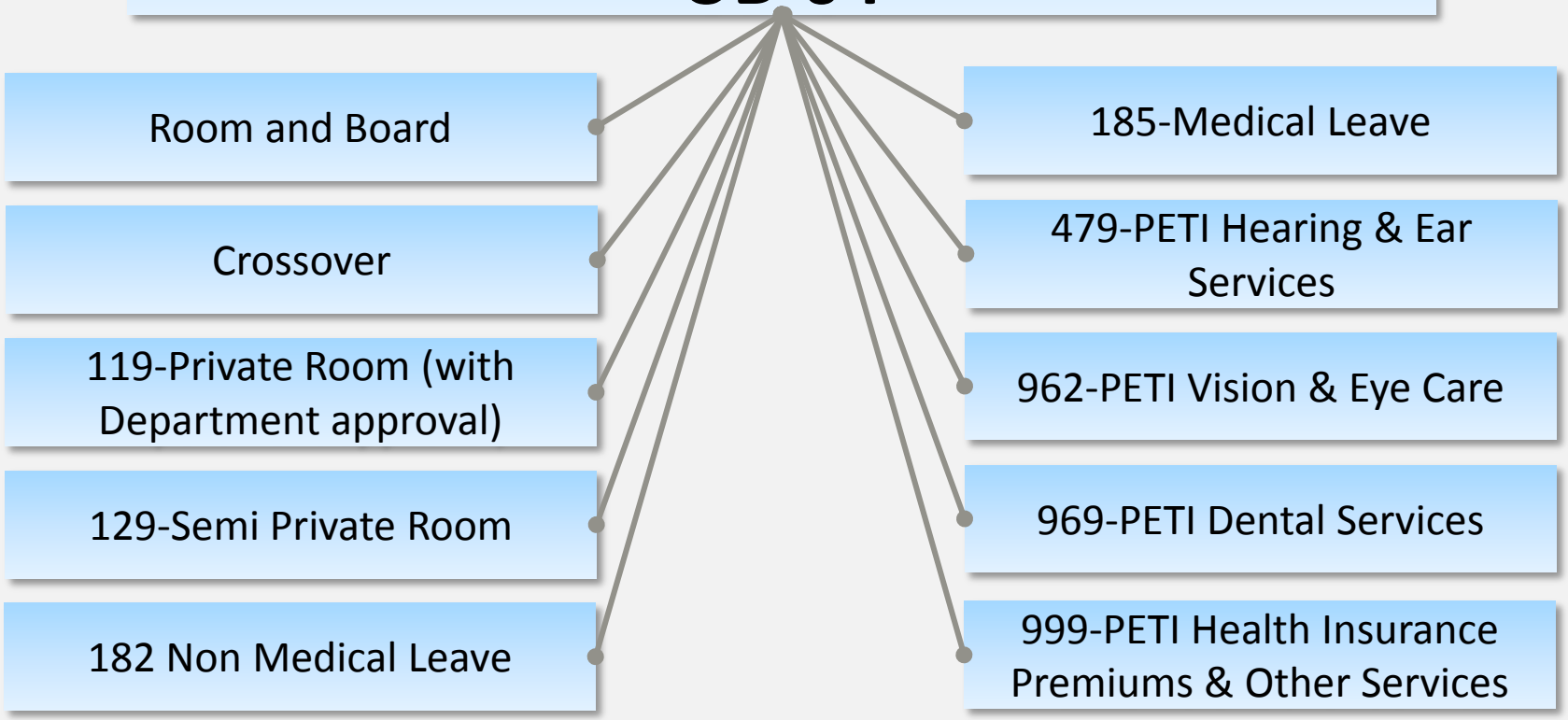
- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

Extensions – **Backdated Eligibility**

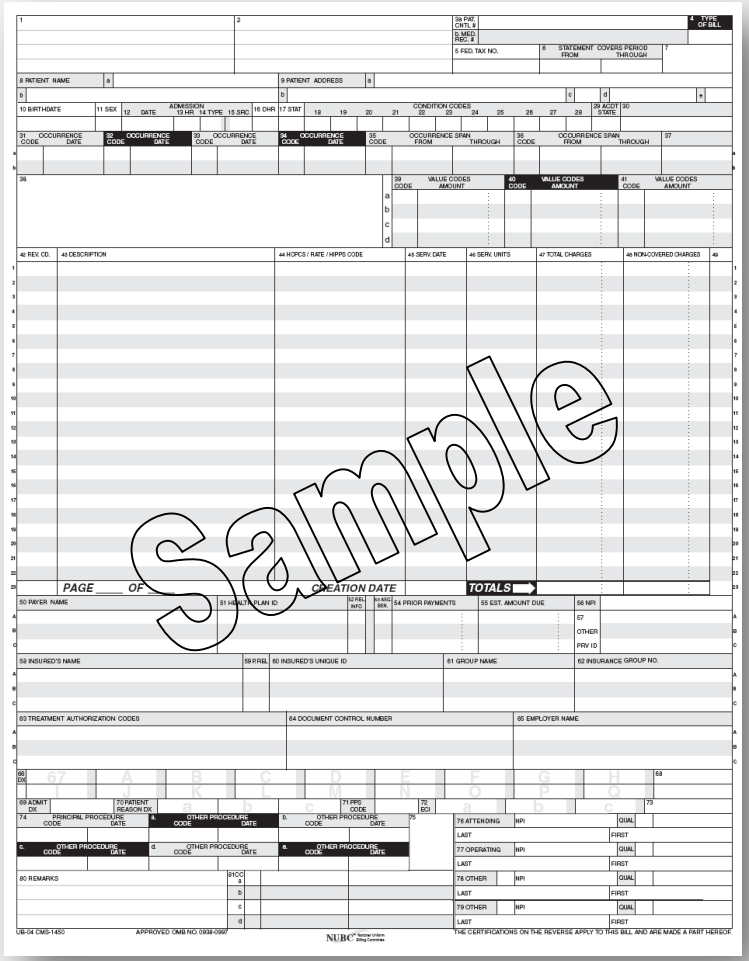
- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated

UB-04

Examples of NF Services Billed on UB-04

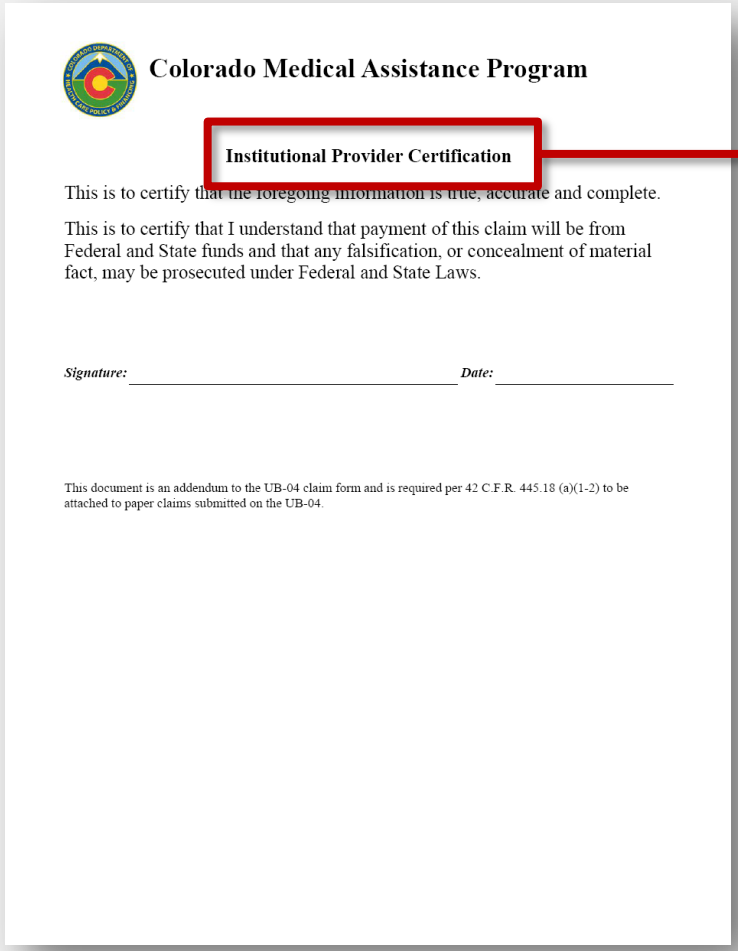


UB-04



- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers

UB-04 Certification



Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ ***Date:*** _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

UB-04 certification must be completed and attached to all claims submitted on the paper UB-04

Print a copy of the certification at: colorado.gov/hcpf/provider-forms

UB-04 Tips

Do

- Submit multiple-page claims electronically

Do not

- Submit "continuous" claims
- Add more lines on the form
  - Each claim form has set number of available billing lines
  - Billing lines in excess of designated number are **not processed or acknowledged**

UB-04 Coding Reminders

Use Value Codes to indicate -

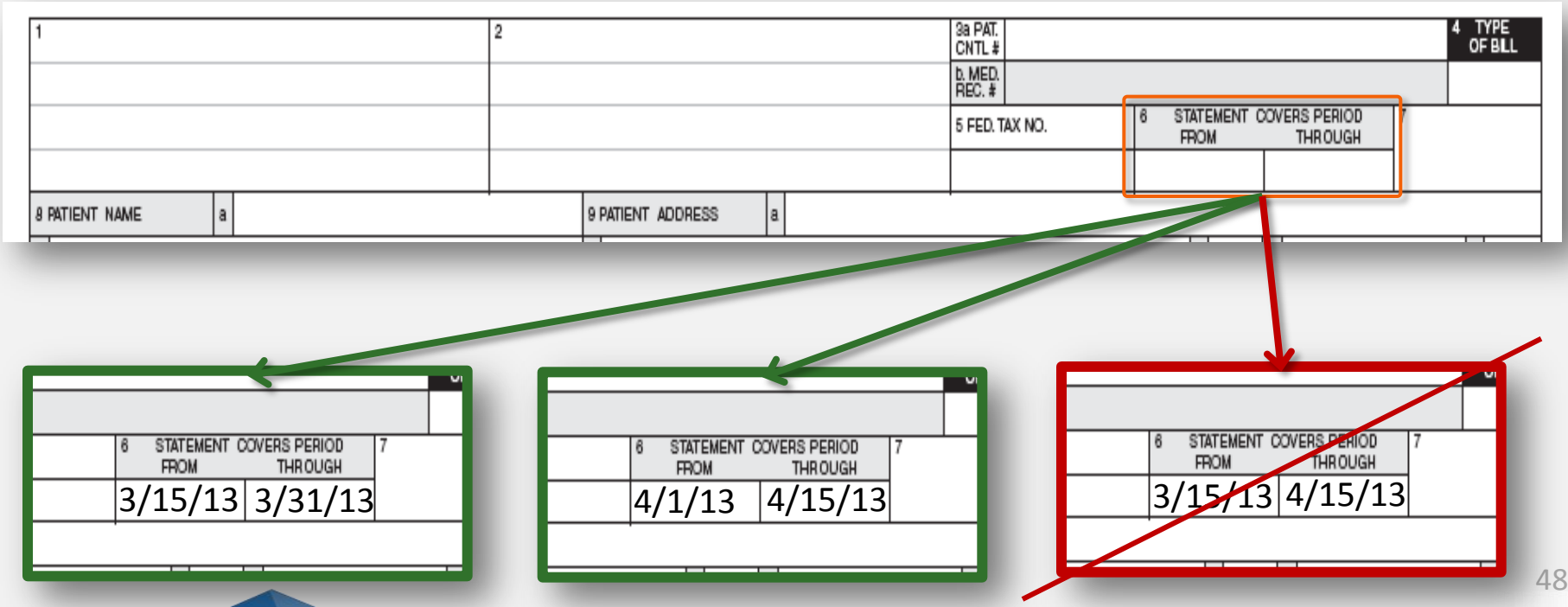
Patient Liability (Patient Payment)
- Value Code 31

Covered Days
- Value Code 80

Non-Covered Days
- Value Code 81

UB-04 Coding Reminders

Statement Covers Period –
"From" and "Through" dates must be within same calendar month



UB-04 Coding Reminders

- If member is admitted and discharged on same date:
  - that date should appear as both the “From” and “Through” dates of service
- NFs are paid:
  - for date of admission
  - but not date of discharge
- Using Medicaid billing codes incorrectly can result in losing important member data
- Do not to code claims as discharges if member is expected to return
- Discharge can generate Occurrence Code 42
  - This code can automatically end date Nursing Facility PARs

Medical Leave Days

- When member is in nursing facility and has a hospital inpatient stay during the same month:
  - Only one of the providers may be reimbursed for a given calendar day
  - NF - submit medical leave claim for days member was in hospital
    - including date of hospital admission
  - Hospital receives payment for services on date of admission without overlapping nursing facility payment dates
  - If NF bills per diem for days in the hospital
    - Second claim processed will deny
    - NF must adjust its claim so hospital can be paid

Medical Leave Days Example

- Member is admitted to hospital, but expected to return
  - To indicate medical leave days:
    - Use Value Code 81 with number of days member is in hospital
    - Use Revenue Code 185
  - To indicate that member is expected to return
    - Use Type of Bill (TOB) 223 or 623
    - Use Status Code 30 (still a patient)

Non-Medical Leave Days Example

- Member leaves to visit family, but is expected to return
  - NF can be paid for 42 non-medical leave days per calendar year
  - Non-medical leave days must be approved by member's physician
  - To indicate paid non-medical leave days
    - Use Revenue Code 182 for non-medical leave days
  - To indicate unpaid non-medical leave days
    - Use Value Code 81 with number of non-covered days
    - Use Revenue Code 182 for non-medical leave days

Discharge Reminders

- If member is discharged to another facility, to home, or expires:
  - Type of Bill should end in 1 (221 or 621) or 4 (224 or 624)
  - Discharge date not covered by Medicaid
  - Status Code should reflect the discharge
  - NF must report the discharge to Masspro, the Single Entry Point (SEP) agency, and the county
    - Masspro end dates the PAR and sends a revised PAR to the Department's fiscal agent

Hospital Members in a Nursing Facility

- ULTC 100.2 required for admission if:
  - Medicaid eligibility for hospice member is pending
  - Member's type of eligibility is HCBS
    - Required prior to 30th day of member not using HCBS services, which could be prior to 30 days in the nursing facility
    - In most cases, will not be required prior to admission
    - Single Entry Point Agency (SEP) can verify when HCBS services will expire

Hospital Members in a Nursing Facility

- ULTC 100.2 not required for admission if
  - Member's eligibility type is NF and ULTC 100.2 is not expired
  - Member has a type of eligibility that will continue while in the NF
    - Check with county or eligibility site to determine if types of eligibility (other than NF or HCBS) will require a ULTC 100.2

Hospital Members in a Nursing Facility

- ULTC 100.2 **required later** for admission if:
  - Member does not have active ULTC 100.2, leaves hospice status, and remains in the nursing facility
  - Member's eligibility type is NF and the ULTC 100.2 expires
    - Current ULTC 100.2 is required for annual eligibility redetermination

Continued Stay Reviews

- Tracking ULTC 100.2 End Dates
  - Official member length of stay end dates are on the ULTC 100.2 located on the certification page
    - Notify authorization agent with any errors on notification letter
    - Notify SEP of need for re-certification at least 10 days before length of stay end date
    - Refer to Nursing Facility Billing Manual
  - Member is not responsible to pay privately if recertification is delayed due to NF error

Post Eligibility Treatment of Income (PETI)

If a member does not make a patient payment - there is No PETI!!

To Access PETI

- **All** other payer sources must have been **exhausted**
- **Cannot** be a covered Medicaid service

OR

- Must have Medicaid denial
  - You must first submit a claim to the Colorado Medical Assistance program

PETI Process Overview

- NF or family pays provider
  - Usually done once PETI approval received

- NF reports PETI on:
  - 837I
  - UB-04

To Submit PETI Request

- All NF PETI requests must include the following two forms
  - Nursing Facility Post Eligibility Treatment of Income Request (NF PETI) Program form
  - NF PETI Medical Necessity Certification form
- All required signatures
- All supporting documents
- Provider statement
- Provider's invoice
- Medicaid Program denial PCR (if applicable)

PETI – Submit to Fiscal Agent

- May submit NF PETI directly to the Department's fiscal agent, without first submitting to the Department if:
  - All combined request(s) per calendar year are under $400
  - Requested service is not an adult benefit of Medicaid per PETI fee schedule

PETI – Submit to Department

- Submit to the Department first if:
  - Charges exceeding $400 per year and all health insurance charges must be prior authorized by Department
  - If the fee schedule notes an MP (Manually Priced) then submit to the department

PETI Billing

- Provider is not required to be enrolled in Medicaid in order to provide services to PETI-eligible residents
- Submit claims for approved NF PETI amounts on claim with:
  - member's room and board amount
  - patient liability amount
- Claims processing system automatically completes the calculations
- PETI documentation shall be retained by NF for 6 years for audit purposes

PETI – If…Then

If: provider is requesting more than what is allowed on PETI fee schedule

→

Then: this amount must be amended to what is allowable on the PETI fee schedule

If: member has medical trust

→

Then: PETI charges must be paid from medical trust

Dental PETI

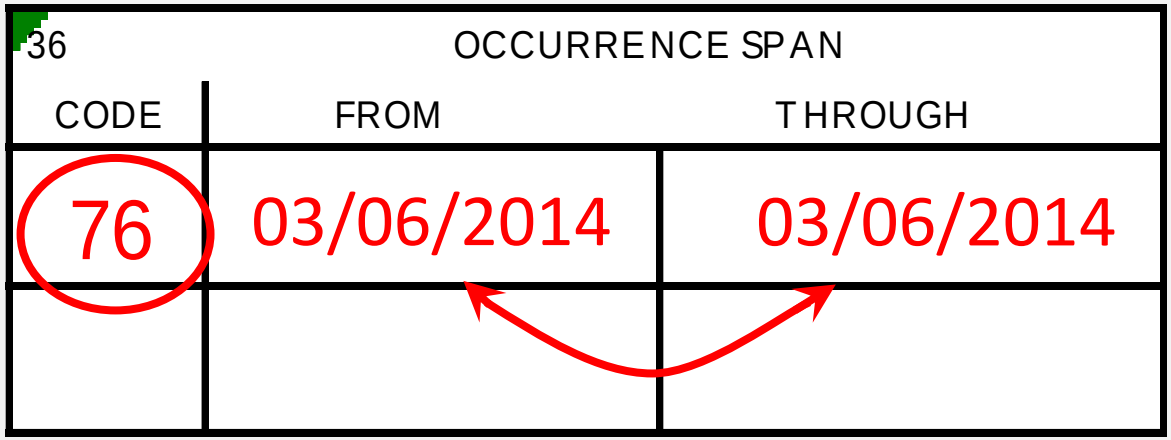
- Starting April 1st, 2014 there is a new adult Dental benefit
- All Medicaid Adults now have an annual $1000 benefit
- Nursing Facilities will no longer be required to submit PETI requests for routine dental services
  - Refer to Dental Billing Manual
- The new benefit will have no impact on other PETI benefits, such as:
  - Hearing aids
  - Eyeglasses
  - Health insurance premiums

PETI Revenue Codes

- 999 – Health Insurance Premiums & Other Services
  - All premiums must first be approved by State
- 962 – Vision & Eye Care
- 479 – Hearing & Ear Services
- Claims must have Accommodation Revenue Code:
  - 119 Private
    - Must be approved by Colorado Medicaid
  - 129 Semi-Private
- Claims must have a patient liability

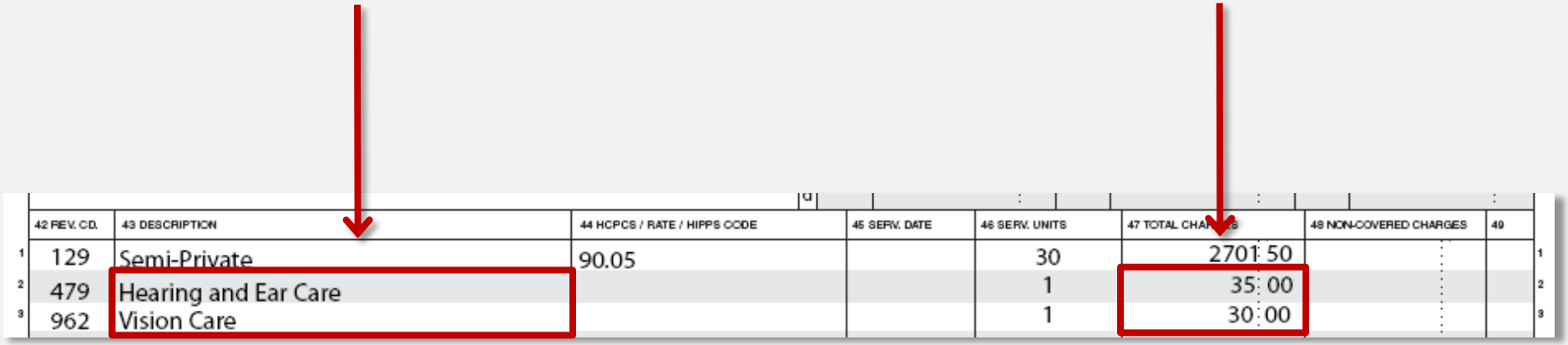
PETI Occurrence Span Dates

- Date(s) services rendered or insurance payments made
  - May be single dates
  - No future dates
- Span dates do not have to fall within Statement Covers Period



PETI Services

- Enter approved amount paid to service providers



	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	129	Semi-Private	90.05		30	2701 50		1
2	479	Hearing and Ear Care			1	35 00		2
3	962	Vision Care			1	30 00		3

PETI Services

- Charges must be less than or equal to patient payment entered for Value Code 31 (Patient Liability Amount)

39		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	80	30 00				
	b	31	103 00				
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Semi-Private	90.05		30	2 50		
479	Hearing and Ear Care			1	35 00		
962	Vision Care			1	30 00		

Nursing Facility Contacts

To send NF PETI requests to the Department

Nursing Facility PETI Program
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Fax: 303.866.3991

For NF PETI related questions
not directly related to billing

please contact Susan Love at 303-866-4158

Common Denial Reasons

Timely Filing	Claim was submitted more than 120 days without a LBOD
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid.
Bill Medicare or Other Insurance	Medicaid is always the "Payor of Last Resort". Provider should bill all other appropriate carriers first

Common Denial Reasons

PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total
Type of Bill	Claim was submitted with an incorrect or invalid type of bill

Claims Process - Common Terms

Reject

Claim has primary data edits – **not** accepted by claims processing system

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

Claim processed & paid by claims processing system

Claims Process - Common Terms

Correcting under/overpayments, claims paid at zero & claims history info

Adjustment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

Suspend

"Cancelling" a "paid" claim (wait 48 hours to rebill)

Void

Adjusting Claims

- **What is an adjustment?**
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

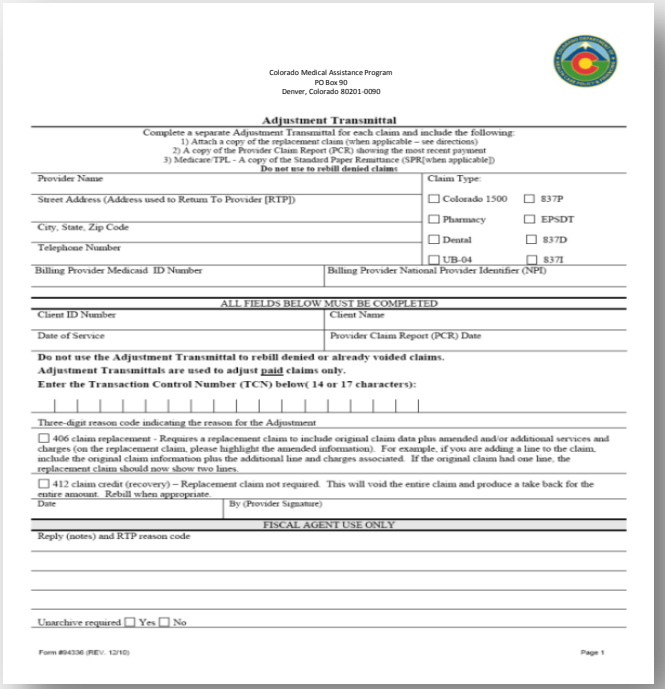
Adjust a claim when:

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when:

- Claim was denied
- Claim is in process
- Claim is suspended

Adjustment Methods



Colorado Medical Assistance Program
PO Box 90
Denver, Colorado 80201-0090

Adjustment Transmittal

Complete a separate Adjustment Transmittal for each claim and include the following:
1) Attach a copy of the replacement claim (when applicable – see directions)
2) A copy of the Provider Claim Report (PCR) showing the most recent payment
3) Medicare/TPL - A copy of the Standard Paper Remittance (SPR)(when applicable])
Do not use to rebill denied claims

Provider Name
Street Address (Address used to Return To Provider [RTP])
City, State, Zip Code
Telephone Number
Billing Provider Medicaid ID Number
Billing Provider National Provider Identifier (NPI)

Claim Type:
☐ Colorado 1500 ☐ 837P
☐ Pharmacy ☐ EPSDT
☐ Dental ☐ 837D
☐ UB-04 ☐ 837I

ALL FIELDS BELOW MUST BE COMPLETED

Client ID Number
Client Name
Date of Service
Provider Claim Report (PCR) Date

Do not use the Adjustment Transmittal to rebill denied or already voided claims.
Adjustment Transmittals are used to adjust paid claims only.
Enter the Transaction Control Number (TCN) below(14 or 17 characters):

Three-digit reason code indicating the reason for the Adjustment

☐ 406 claim replacement - Requires a replacement claim to include original claim data plus amended and/or additional services and charges (on the replacement claim, please highlight the amended information). For example, if you are adding a line to the claim, include the original claim information plus the additional line and charges associated. If the original claim had one line, the replacement claim should now show two lines.

☐ 412 claim credit (recovery) – Replacement claim not required. This will void the entire claim and produce a take back for the entire amount. Rebill when appropriate.

Date
By (Provider Signature)

FISCAL AGENT USE ONLY

Reply (notes) and RTP reason code

Unarchive required ☐ Yes ☐ No

Form #04336 (REV. 12/10)
Page 1

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete Adjustment Transmittal form
- Be concise & clear

Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

****
* CLAIMS PAID *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	DATES OF SVC TO	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
7015	CLIENT, IMA	Z000000	04080000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
PROC CODE - MODIFIER 99214 -				040508	040508	132.00	69.46	2.00		

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

Denied

* CLAIMS DENIED *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	30800000000000003	03/05/08	03/06/08	245.04	1348

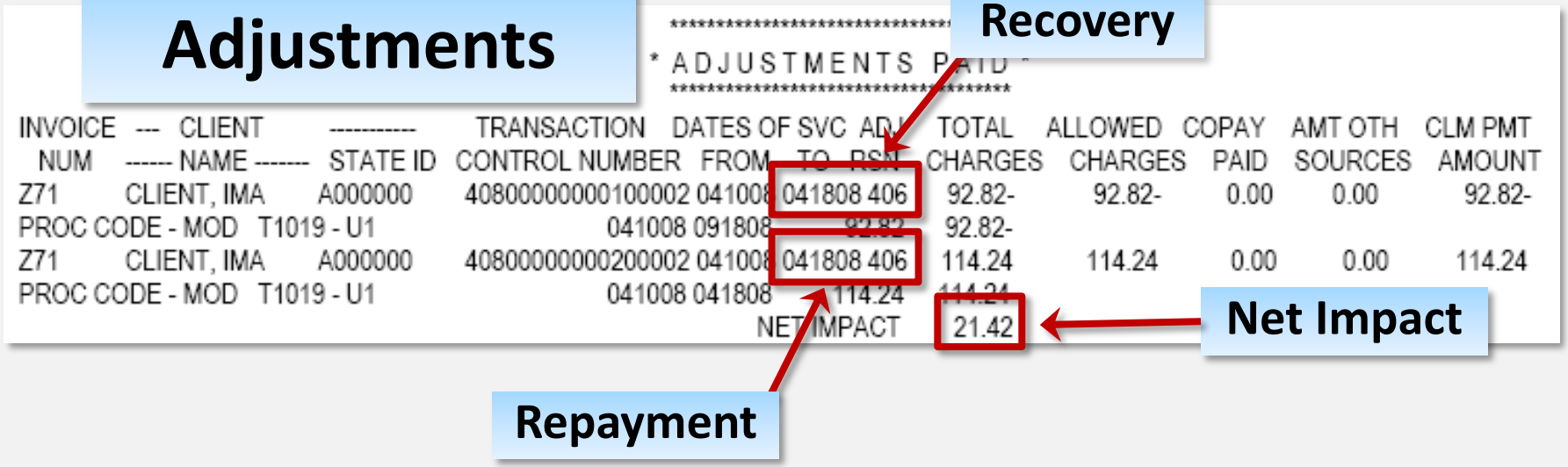
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments



****
* ADJUSTMENTS PAID *
****

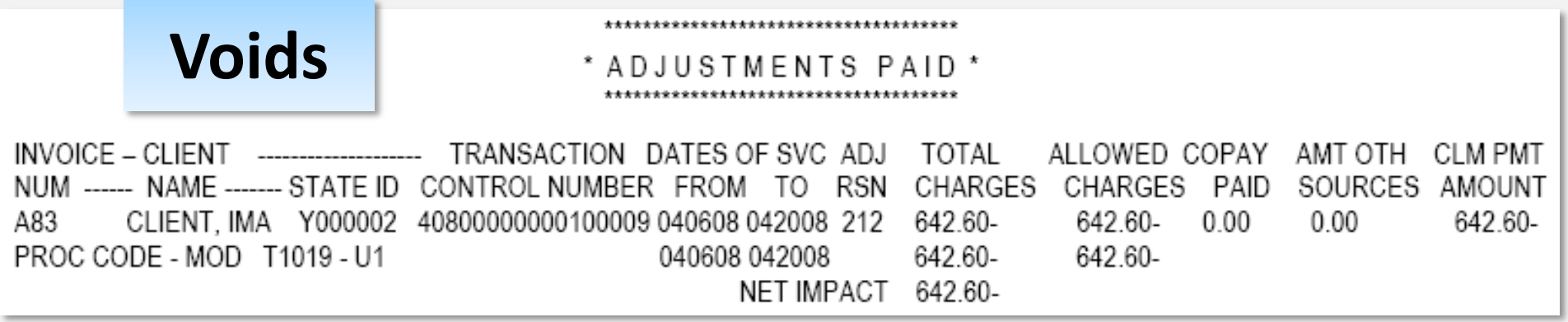
INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	DATES OF SVC TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1				041008	091808		92.82-				
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1				041008	041808		114.24	114.24			
						NET IMPACT	21.42				

Recovery

Net Impact

Repayment

Voids



****
* ADJUSTMENTS PAID *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	DATES OF SVC TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00	642.60-
PROC CODE - MOD T1019 - U1				040608	042008		642.60-	642.60-			
						NET IMPACT	642.60-				

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/ Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank You!